



# Prevention of perinatal death and adverse perinatal outcome using low-dose aspirin: a meta-analysis

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**KEYWORDS:** aspirin; meta-analysis; perinatal death; pre-eclampsia

## ABSTRACT

**Objective** To compare early vs late administration of low-dose aspirin on the risk of perinatal death and adverse perinatal outcome.

**Methods** Databases were searched for keywords related to aspirin and pregnancy. Only randomized controlled trials that evaluated the prophylactic use of low-dose aspirin (50–150 mg/day) during pregnancy were included. The primary outcome combined fetal and neonatal death. Pooled relative risks (RR) with their 95% CIs were compared according to gestational age at initiation of low-dose aspirin ( $\leq 16$  vs  $> 16$  weeks of gestation).

**Results** Out of 8377 citations, 42 studies (27 222 women) were included. Inclusion criteria were risk factors for pre-eclampsia, including: nulliparity, multiple pregnancy, chronic hypertension, cardiovascular or endocrine disease, prior gestational hypertension or fetal growth restriction, and/or abnormal uterine artery Doppler. When compared with controls, low-dose aspirin started at  $\leq 16$  weeks' gestation compared with low-dose aspirin started at  $> 16$  weeks' gestation was associated with a greater reduction of perinatal death (RR = 0.41 (95% CI, 0.19–0.92) vs 0.93 (95% CI, 0.73–1.19),  $P = 0.02$ ), pre-eclampsia (RR = 0.47 (95% CI, 0.36–0.62) vs 0.78 (95% CI, 0.61–0.99),  $P < 0.01$ ), severe pre-eclampsia (RR = 0.18 (95% CI, 0.08–0.41) vs 0.65 (95% CI, 0.40–1.07),  $P < 0.01$ ), fetal growth restriction (RR = 0.46 (95% CI, 0.33–0.64) vs 0.98 (95% CI, 0.88–1.08),  $P < 0.001$ ) and preterm birth (RR = 0.35 (95% CI, 0.22–0.57) vs 0.90 (95% CI, 0.83–0.97),  $P < 0.001$ ).

**Conclusion** Low-dose aspirin initiated at  $\leq 16$  weeks of gestation is associated with a greater reduction of perinatal death and other adverse perinatal outcomes than when initiated at  $> 16$  weeks. Copyright © 2013 ISUOG. Published by John Wiley & Sons Ltd.

## INTRODUCTION

The leading causes of perinatal death are preterm birth, fetal abnormalities and impaired placentation leading to pre-eclampsia and fetal growth restriction (FGR)<sup>1–4</sup>. Meta-analyses of randomized studies suggest that prophylactic use of low-dose aspirin initiated at or before the 16<sup>th</sup> week of pregnancy is associated with significant reduction in the prevalence of severe pre-eclampsia, FGR and preterm birth, all placenta-related complications of pregnancy<sup>5–7</sup>. The mechanism of action of aspirin remains unclear but it could include an improvement of the transformation of uterine spiral arteries, which is typically incomplete in pre-eclampsia<sup>8,9</sup>. Haapsamo *et al.* observed that low-dose aspirin could lead to an improvement of uterine artery blood flow that is related to the transformation of uterine spiral arteries<sup>10,11</sup>. Trophoblastic invasion of uterine spiral arteries normally starts at around 8–10 weeks; is mostly completed by 16–18 weeks; but can continue until 22 weeks<sup>12</sup>. We believe that intervention aiming at the improvement of this process should probably be initiated as early as 8–10 weeks and no later than 16–18 weeks, when possible. We suggest that improvement of deep placentation could lead to a reduction of several adverse pregnancy outcomes and to a reduction of perinatal death.

The objective of the current work was to perform a systematic review and meta-analysis including recent randomized trials and to compare the effect of early and late administration of aspirin on the risk of perinatal death and other adverse perinatal outcomes.

## METHODS

We generated a list of keywords and MeSH terms 'aspirin', 'antiplatelet', 'acetylsalicylic acid', 'ASA', 'pregnancy-complication' and 'pregnancy', for extensive databases search. EMBASE, PubMed, the Cochrane Central Register of Controlled Trials (CENTRAL) and Web of Science

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were used and relevant citations were extracted from 1965 to October 2011. No language restriction was imposed. A first reviewer (S.R.) screened all titles and selected citations for more detailed evaluation. The second sort retrieved citations and abstracts and was revised by two reviewers (S.R. and S.D.). The same two reviewers read and selected all relevant trials. Other systematic reviews were used for additional search<sup>5–7,13–16</sup>. Corresponding or primary authors were contacted for additional information when necessary. The quality and integrity of this review were validated with PRISMA: preferred reporting items for systematic reviews and meta-analyses<sup>17</sup>.

Only prospective, randomized, controlled trials involving pregnant women treated with low-dose aspirin (150 mg or less), with or without dipyridamole (300 mg or less), were included. The control group had to be allocated to placebo or no treatment. Trials that involved other treatment, such as subcutaneous heparin or calcium, were excluded. All studies that involved women who initiated treatment at  $\leq 16$  weeks of gestation and at  $>16$  weeks of gestation were included in the meta-analysis. The quality of studies was evaluated using Cochrane Handbook Criteria tool for judging risk of bias, and studies with high risk of bias were considered for sensitivity analysis<sup>18,19</sup>.

The principal outcome of interest was perinatal mortality defined as fetal death after 16 weeks' gestation or neonatal death before 28 days of age or similar definition. We collected the reasons for perinatal death when available. Our secondary outcomes included pre-eclampsia, severe pre-eclampsia, FGR (reported as below the 10<sup>th</sup>, the 5<sup>th</sup> or the 3<sup>rd</sup> percentile), preterm birth, placental abruption, birth weight and gestational age at delivery.

## Statistical analysis

Review Manager 5.0.25 software (The Nordic Cochrane Centre, The Cochrane Collaboration, Copenhagen, Denmark) and the SAS 9.2 software (SAS Institute Inc., Cary, NC, USA) were used for analysis. Relative risks (RR) were calculated for each study and were pooled for global analysis with 95% CIs and stratified according to gestational age at entry ( $\leq 16$  weeks *vs*  $>16$  weeks; determined pre-hoc). Difference between subgroups of gestational age at entry was evaluated by mixed regression, weighted by the size of each study. Global RR was calculated according to DerSimonian and Laird random-effect models in case of significant heterogeneity and with fixed effect in case of homogeneity between studies<sup>20,21</sup>. Heterogeneity between studies was analyzed using the Higgins I<sup>2</sup> statistic<sup>22,23</sup>. The distribution of trials was examined using funnel plots to assess publication bias<sup>24</sup>. Sensitivity analysis was conducted to investigate robustness of the findings and heterogeneity between studies, with comparison for the dose of aspirin, use of dipyridamole, blinding, statistical model, trial size and risk of bias.

## RESULTS

The literature search identified 8377 citations from which we identified 1104 potentially eligible studies that were completely reviewed (Figure 1). The inclusion criteria were met by 66 studies, but only 42 of those were included (27222 women randomized)<sup>25–68</sup> in the final analysis because several studies recruited over a range of gestational age overlapping 16 weeks. Studies included nulliparous women or women identified at high risk for pre-eclampsia based on medical history and/or ultrasonographic findings (Table S1). In two

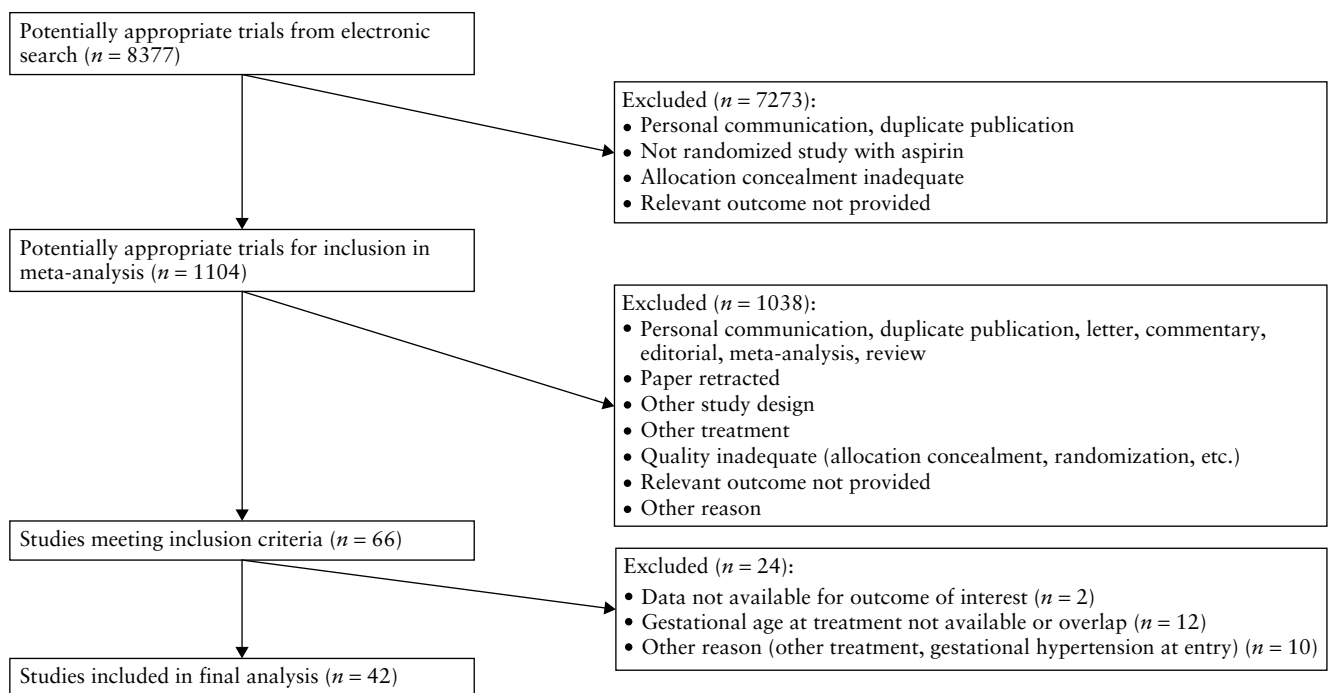


Figure 1 Flow diagram showing selection process of articles.

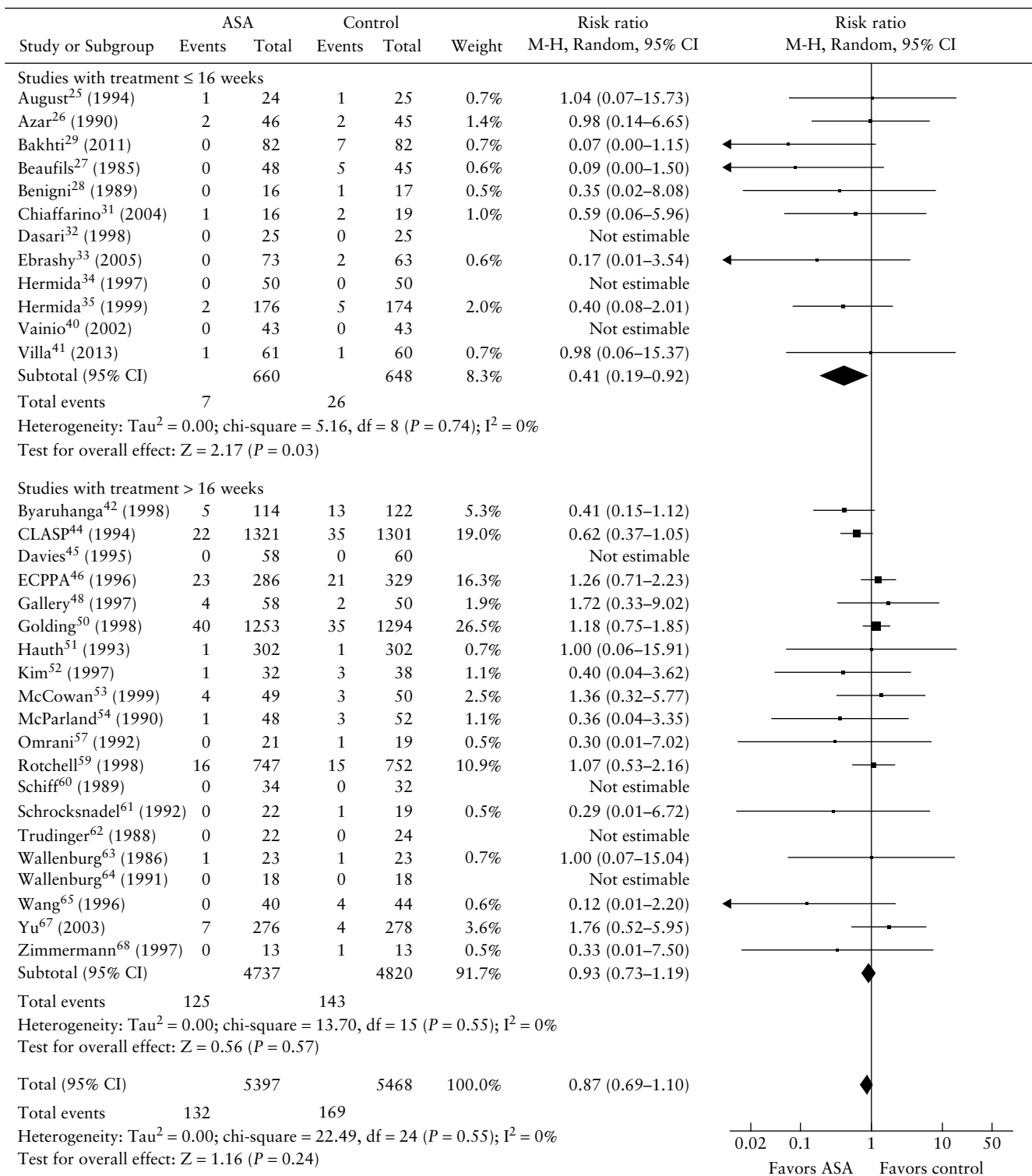


Figure 2 Forest plot of effect of low-dose aspirin on risk of perinatal death, subgrouped by gestational age at initiation of treatment. Only the first author of each study is given. df, degrees of freedom; M-H, Mantel-Haenszel.

studies the intervention was aspirin in combination with dipyridamole, and in the other studies aspirin was the only medication administered. In 32 studies, women allocated to the control group received a placebo and in 10 studies they received no treatment. The follow-up rate was greater than 80% in 14 out of 15 studies that initiated the treatment at ≤ 16 weeks and in 26 out of 27 studies that initiated the treatment after 16 weeks.

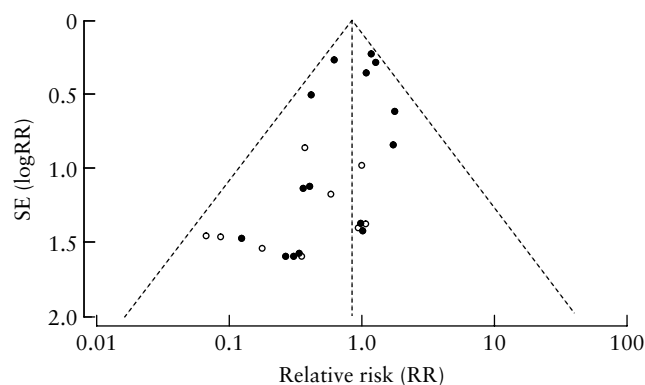
The trial characteristics, including number of patients, inclusion criteria, treatment for cases and controls, and outcome measure in the studies where aspirin treatment was initiated at ≤ 16 weeks' gestation and > 16 weeks are summarized in Table S1.

Administration of low-dose aspirin starting at ≤ 16 weeks was associated with a significant reduction in the risk of perinatal death, but the effect of treatment was

**Table 1** Perinatal outcomes associated with low-dose aspirin according to gestational age (GA) at initiation of intervention

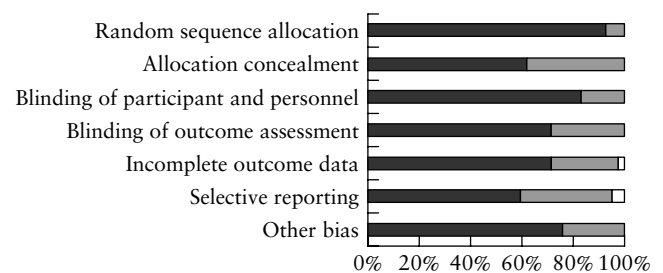
Outcome/ GA at initiation of intervention	Trials (n)	Participants (n)	Prevalence		Relative risk (95% CI) (random effect)	P	I <sup>2</sup> (Higgins test)	P (between subgroups)
			Treated (%)	Controls (%)				
Perinatal death	32	10 865	2.4	3.1	0.87 (0.69 to 1.10)	NS	0%	
≤ 16 weeks	12	1308	1.1	4.0	0.41 (0.19 to 0.92)	0.03	0%	0.02
> 16 weeks	20	9557	2.6	3.0	0.93 (0.73 to 1.19)	NS	0%	
Pre-eclampsia	33	12 152	7.5	9.6	0.62 (0.49 to 0.78)	<0.001	53%	
≤ 16 weeks	13	1479	7.6	17.9	0.47 (0.36 to 0.62)	<0.001	0%	<0.01
> 16 weeks	20	10 673	7.5	8.4	0.78 (0.61 to 0.99)	0.04	49%	
Severe pre-eclampsia	11	2143	2.8	7.5	0.36 (0.20 to 0.63)	<0.001	24%	
≤ 16 weeks	6	649	1.5	12.3	0.18 (0.08 to 0.41)	<0.001	0%	<0.01
> 16 weeks	5	1494	3.3	5.5	0.65 (0.40 to 1.07)	NS	0%	
Fetal growth restriction	27	8260	10.7	12.3	0.86 (0.75 to 0.99)	0.04	28%	
≤ 16 weeks	10	1064	8.0	17.6	0.46 (0.33 to 0.64)	<0.001	0%	<0.001
> 16 weeks	17	7196	11.1	11.5	0.98 (0.88 to 1.08)	NS	0%	
Preterm birth	22	11 302	17.4	20.3	0.81 (0.71 to 0.92)	<0.01	39%	
≤ 16 weeks	6	904	4.8	13.4	0.35 (0.22 to 0.57)	<0.001	0%	<0.001
> 16 weeks	16	10 398	18.6	20.8	0.90 (0.83 to 0.97)	<0.01	0%	
Placental abruption	10	4175	2.3	1.9	1.24 (0.79 to 1.95)	NS	3%	
≤ 16 weeks	4	592	2.3	5.1	0.55 (0.21 to 1.47)	NS	5%	NS
> 16 weeks	6	3583	2.3	1.4	1.56 (0.96 to 2.55)	NS	0%	
Mean difference (95% CI)						P		
Birth weight (g)	23	2787	124 (68 to 180)		<0.001		45%	
≤ 16 weeks	10	1061	209 (100 to 319)		<0.001		69%	NS
> 16 weeks	13	1726	71 (18 to 124)		<0.01		0%	
GA at delivery (weeks)	18	1860	0.57 (0.13 to 1.01)		0.01		88%	
≤ 16 weeks	9	959	1.06 (0.40 to 1.72)		0.002		93%	0.048
> 16 weeks	9	901	-0.01 (-0.55 to 0.52)		NS		55%	

NS, not significant.



**Figure 3** Funnel plot of distribution of relative risk for perinatal death associated with aspirin treatment for studies included in our analysis. Black circles represent studies in which aspirin treatment was initiated at or before 16 weeks' gestation and white circles represent studies in which treatment was initiated after 16 weeks. SE, standard error.

not significant when aspirin was initiated after 16 weeks (Figure 2 and Table 1). The difference in RR according to gestational age at entry ( $\leq 16$  weeks *vs*  $> 16$  weeks) was statistically significant ( $P = 0.02$ ). The difference in RR according to gestational age at entry remained statistically significant ( $P = 0.03$ ) when comparing women recruited at  $\leq 16$  weeks with those recruited between 17 and 24 weeks (RR = 1.01 (95% CI, 0.49–2.08),  $P = 0.99$ ). Only seven (22%) studies reported the reasons for perinatal death and therefore few conclusions can be drawn<sup>25,48,50,57,60,63,64</sup>. However, 17 (65%) out of 26



**Figure 4** Assessment of risk of bias in studies included in our analysis (low (■), unclear (▒), high (□)) following the Cochrane Handbook<sup>18</sup>.

perinatal deaths reported in those studies were related to placental-mediated complications of pregnancy (pre-eclampsia, FGR and/or placental abruption). Significant risk reductions were also observed for pre-eclampsia, severe pre-eclampsia, FGR, preterm birth, birth weight and gestational age at delivery when aspirin was administered at or before 16 weeks (Table 1). Low-dose aspirin administered after 16 weeks was associated with a modest, but significant, reduction of pre-eclampsia and preterm birth and with no significant reduction of FGR. There is insufficient evidence to conclude on the effect of low-dose aspirin given after 16 weeks on the risk of severe pre-eclampsia (RR = 0.65; 95% CI, 0.40–1.07).

The Higgins  $I^2$  statistic did not show significant heterogeneity between studies in the global and the subgroup analyses ( $I^2 = 0\%$ ) for perinatal death. However, for several outcomes there was significant

heterogeneity between studies that recruited after 16 weeks and consequently random effect was used. Analysis of the funnel plot for perinatal death suggests the possibility of publication bias because small studies with no beneficial effect were missing (Figure 3)<sup>69</sup>. According to the Cochrane Handbook Criteria tool for judging risk of bias, the majority of included studies were judged to have low or unclear risk of bias, except for one study with more than 20% of individuals lost to follow-up and two with a risk of selective reporting (Figure 4)<sup>18,29,30,41,53</sup>. Exclusion of these three studies did not affect the results. No statistical difference was observed between any of the subgroups identified in the sensitivity analysis (Figure 5).

Finally, we found similar effects of early aspirin prophylaxis in women who received  $\leq 80$  mg daily and those who received  $\geq 100$  mg daily (Table 2) and in women who were selected using abnormal uterine artery Doppler as an inclusion criterion as compared with those selected using anamnesis factors only (Table 3).

**DISCUSSION**

Our meta-analysis suggests that the prophylactic use of low-dose aspirin is associated with a significant decrease in perinatal death, provided the treatment is initiated at or before 16 weeks of gestation. Low-dose aspirin initiated at or before 16 weeks is also associated with a significant and greater reduction of pre-eclampsia, FGR and preterm birth than is low-dose aspirin started after

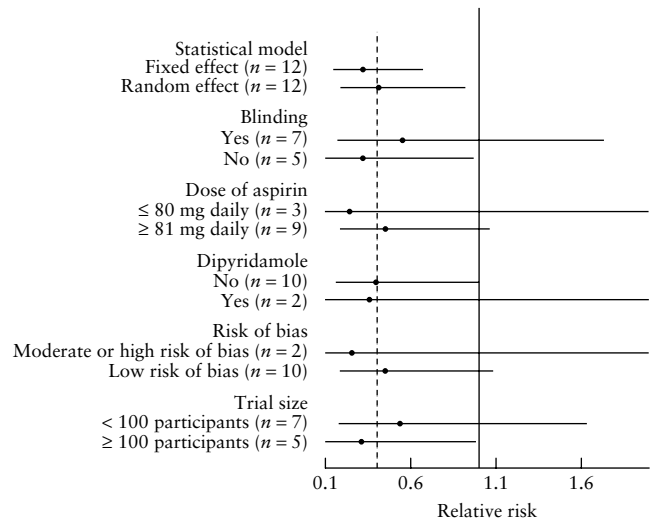


Figure 5 Sensitivity analysis of relative risk for perinatal death for studies in which aspirin treatment was initiated at  $\leq 16$  weeks. The dashed vertical line shows the relative risk obtained from random effects meta-analysis of all included studies.

16 weeks of gestation. This finding is in agreement with a similar meta-analysis published in 2010<sup>7</sup>. Since then, four additional randomized trials that recruited high-risk women prior to 16 weeks' gestation were published and their findings were consistent with our previous results<sup>29,30,36,37,41</sup>. Moreover, the addition of two trials changed the conclusion regarding the effect of aspirin

Table 2 Perinatal outcomes associated with aspirin started before 16 weeks according to dose of aspirin prescribed

Outcome/ dose of aspirin	Trials (n)	Participants (n)	Prevalence		Relative risk (95% CI) (random effect)	P	P (between subgroups)
			Treated (%)	Controls (%)			
Perinatal death							
$\leq 80$ mg	3	255	0	2.4	0.24 (0.03 to 2.14)	NS	
$\geq 100$ mg	9	1053	1.3	4.4	0.45 (0.19 to 1.06)	NS	NS
Pre-eclampsia							
$\leq 80$ mg	5	401	14.1	31.8	0.35 (0.16 to 0.76)	<0.001	
$\geq 100$ mg	8	1078	5.2	12.9	0.46 (0.30 to 0.71)	<0.01	NS
Severe pre-eclampsia							
$\leq 80$ mg	2	222	0.9	10.4	0.12 (0.02 to 0.65)	0.01	
$\geq 100$ mg	4	427	1.8	13.2	0.20 (0.08 to 0.53)	0.02	NS
Fetal growth restriction							
$\leq 80$ mg	4	301	12.2	22.8	0.52 (0.32 to 0.87)	0.01	
$\geq 100$ mg	6	763	6.2	15.6	0.41 (0.26 to 0.64)	<0.001	NS
Preterm birth							
$\leq 80$ mg	2	169	4.4	17.7	0.27 (0.09 to 0.77)	0.01	
$\geq 100$ mg	4	735	4.9	13.7	0.38 (0.20 to 0.69)	<0.01	NS
Placental abruption							
$\leq 80$ mg	0	—	—	—	—	—	
$\geq 100$ mg	4	592	2.3	5.1	0.55 (0.21 to 1.47)	NS	N/A
			Mean difference (95% CI)			P	
Birth weight (g)							
$\leq 80$ mg	4	321		104 (-47 to 254)		NS	
$\geq 100$ mg	6	740		278 (114 to 442)		0.001	NS
GA at delivery (weeks)							
$\leq 80$ mg	2	119		2.00 (-1.61 to 5.62)		NS	
$\geq 100$ mg	6	719		1.09 (0.28 to 1.89)		<0.001	NS

GA, gestational age; N/A, not applicable; NS, not significant.

**Table 3** Perinatal outcomes associated with aspirin started before 16 weeks according to whether abnormal uterine artery (UtA) Doppler was used as an inclusion criterion

Outcome/ inclusion criterion	Trials (n)	Participants (n)	Prevalence		Relative risk (95% CI) (random effect)	P	P (between subgroups)
			Treated (%)	Controls (%)			
<b>Perinatal death</b>							
Abnormal UtA Doppler	3	343	0.6	1.8	0.45 (0.06 to 3.41)	NS	NS
Anamnesis factors only	9	965	1.2	4.8	0.41 (0.17 to 0.97)	0.04	
<b>Pre-eclampsia</b>							
Abnormal UtA Doppler	4	423	16.6	34.0	0.46 (0.26 to 0.82)	<0.01	NS
Anamnesis factors only	9	1056	4.0	11.6	0.39 (0.24 to 0.64)	<0.001	
<b>Severe pre-eclampsia</b>							
Abnormal UtA Doppler	3	343	2.3	11.4	0.25 (0.09 to 0.68)	<0.01	NS
Anamnesis factors only	3	306	0.6	13.2	0.10 (0.02 to 0.40)	0.001	
<b>Fetal growth restriction</b>							
Abnormal UtA Doppler	3	343	9.0	18.1	0.49 (0.28 to 0.84)	0.01	NS
Anamnesis factors only	7	721	7.4	13.3	0.44 (0.29 to 0.67)	<0.001	
<b>Preterm birth</b>							
Abnormal UtA Doppler	2	257	6.0	13.0	0.44 (0.10 to 1.91)	NS	NS
Anamnesis factors only	4	647	4.3	14.9	0.29 (0.17 to 0.52)	<0.001	
<b>Placental abruption</b>							
Abnormal UtA Doppler	0	—	—	—	—	—	N/A
Anamnesis factors only	4	592	2.3	5.1	0.55 (0.21 to 1.47)	NS	
<i>Mean difference (95% CI)</i>						P	
<b>Birth weight (g)</b>							
Abnormal UtA Doppler	3	343	46 (−115 to 206)		NS	NS	
Anamnesis factors only	7	718	274 (137 to 411)		<0.001		
<b>GA at delivery (weeks)</b>							
Abnormal UtA Doppler	1	86	0.30 (−0.48 to 1.08)		NS	NS	
Anamnesis factors only	7	752	1.32 (0.51 to 2.12)		0.001		

GA, gestational age; N/A, not applicable; NS, not significant.

started after 16 weeks from insufficient evidence of effect to evidence of modest, but significant, reduction of the risk of pre-eclampsia<sup>7,53,57</sup>.

In the Cochrane review, low-dose aspirin was associated with an 18% reduction (RR = 0.82; 95% CI, 0.69–0.98) of fetal and neonatal death in women recruited before 20 weeks, but not in women recruited after 20 weeks of gestation (RR = 0.91; 95% CI, 0.73–1.13)<sup>14</sup>. However, the difference between those subgroups was not significant. In a meta-analysis of individual patient data, Askie *et al.* did not find a significant reduction of perinatal death (RR = 0.91; 95% CI, 0.81–1.03) with the use of low-dose aspirin<sup>13</sup>. However, they did not report the data stratified according to gestational age at entry for this outcome. Askie *et al.* did not find a significant impact of gestational age at initiation of aspirin on the risk of pre-eclampsia but the meta-analysis did not include several trials that recruited prior to 16 weeks<sup>26,33,35,39</sup>. As most large trials recruited women at around 20 weeks of gestation, we suggest that this cut-off cannot discriminate the effect of gestational age at initiation of low-dose aspirin.

We selected the 16<sup>th</sup> week of gestation as the gestational age cut-off because placental implantation and transformation of uterine spiral arteries are mostly complete by 16–20 weeks of gestation<sup>12</sup>. More specifically, histological studies suggest that endovascular trophoblastic invasion of uterine spiral arteries starts at around 8–10 weeks of gestation and continues until 22

weeks of gestation<sup>12,70,71</sup>. Some authors suggest a ‘two-wave’ process: the initial decidual phase being completed by around 10 weeks and the later myometrial phase starting at around 14–15 weeks<sup>72,73</sup>, while others suggest a continuous process<sup>71</sup>. We propose that the beneficial effect of aspirin is a consequence of an improvement in the transformation of uterine spiral arteries. This is based on two facts. First, low-dose aspirin is associated with a greater reduction of the preterm and severe forms of pre-eclampsia, which are typically associated with poor placentation<sup>5,6,74–77</sup>. Second, abnormal uterine artery blood flow is present as early as 12 weeks’ gestation in women who will subsequently develop pre-eclampsia, and low-dose aspirin improves uterine artery blood flow between the first and the second trimesters<sup>10,78,79</sup>. With these facts in mind, one could suggest that low-dose aspirin should probably be initiated at around 8–12 weeks’ gestation in high-risk women. An individual patients’ meta-analysis should be used to establish the benefits of aspirin in specific gestational-age subgroups (≤16 weeks’, 17–20 weeks’ and 21–24 weeks’ gestation) and could estimate the benefits of initiating aspirin prophylaxis in women who are first seen after 16 weeks.

This meta-analysis has some limitations. First, none of the included trials was designed to evaluate perinatal death and few reported the reasons for perinatal death. Second, small studies without effect were missing, as seen in the funnel plot, raising the possibility of publication bias.

Third, the definition of perinatal death was heterogeneous between studies. Fourth, we found that the six largest trials that could have had the power to examine the impact of low-dose aspirin on perinatal death recruited women mostly after 16 weeks of gestation<sup>43,44,46,50,51,59</sup>. Finally, our finding was limited by the small size of the studies that recruited at  $\leq 16$  weeks' gestation: each of them individually was underpowered to address perinatal death, which can lead to a lack of precision. However, we found that the effect of low-dose aspirin started at  $\leq 16$  weeks of gestation was significant and homogeneous according to the  $I^2$  test and the sensitivity analysis, and remained significant with the exclusion of the trials at high risk of bias.

In 1979, Crandon and Isherwood found that women taking aspirin for other reasons were less likely to develop pre-eclampsia, and Masotti *et al.* demonstrated a different inhibition of cyclo-oxygenase in platelets and vessel walls by low doses of aspirin<sup>80,81</sup>. Six years later, Beaufls *et al.* published the first randomized controlled trial which demonstrated the beneficial effect of low-dose aspirin, starting at 12–14 weeks of gestation, for the prevention of pre-eclampsia and FGR<sup>27</sup>. Of note, they found a significant reduction in perinatal death. Unfortunately, most subsequent randomized trials evaluating low-dose aspirin recruited women at around 20 weeks of gestation and demonstrated little or no beneficial effect. Such late recruitment is likely to be the consequence of the traditional approach to pregnancy care, where the first hospital visit was delayed to 16 weeks of gestation or later<sup>82</sup>.

Extensive research in the last 20 years has identified a series of early biophysical and biochemical markers of impaired placentation<sup>83</sup>. A combination of maternal characteristics and obstetric and medical history with the measurement of mean arterial pressure, uterine artery pulsatility index and serum pregnancy-associated plasma protein-A and placental growth factor at 11–13 weeks can identify a high proportion of pregnancies at high risk for severe, early-onset pre-eclampsia, FGR, miscarriage and stillbirth<sup>84–86</sup>. The extent to which the administration of low-dose aspirin to such high-risk pregnancies can substantially reduce perinatal death, as suggested by the results of our meta-analysis, remains to be determined.

In conclusion, women at high risk for pre-eclampsia or other placenta-mediated adverse pregnancy outcomes should be offered low-dose aspirin daily starting before 16 weeks of gestation. The benefits of low-dose aspirin initiated after 16 weeks appear to be modest.

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## SUPPORTING INFORMATION ON THE INTERNET



**Table S1** Characteristics of included studies according to gestational age at entry



This article is included in this month's Journal Club.

A slide presentation, prepared by Dr Leona Poon, one of UOG's Editors for Trainees, is available online.